



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Stacy Croft, D.C.

**Respondent Name**

Sentinel Insurance Company, LTD

**MFDR Tracking Number**

M4-16-2600-01

**Carrier's Austin Representative**

Box Number 47

**MFDR Date Received**

April 26, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... This rule goes not to state when multiple IR's are required as a component of a DDE, the DD shall be reimbursed \$50 for each additional IR calculation. Modifier 'MI shall be added to CPT code."

**Amount in Dispute:** \$50.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Payment processed in accordance with Rule 134.204 as follows:

- \$360 MMI Exam
- \$450 IR exam – (2) body areas
- \$500 Extent of compensable injury exam
- \$250 Ability to return to work exam
- \$50 Additional IR exam calculation"

**Response Submitted by:** The Hartford

### SUMMARY OF FINDINGS

| Dates of Service  | Disputed Services                                    | Amount In Dispute | Amount Due |
|-------------------|--|-------------------|------------|
| February 22, 2016 | Designated Doctor Evaluation of Multiple Impairments | \$50.00           | \$0.00     |

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
  - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time.
  - 1115 – We find the original review to be accurate and are unable to recommend any additional allowance.

### **Issues**

1. What are the rules that apply to the dispute?
2. Is the requestor entitled to additional reimbursement for the disputed services?

### **Findings**

1. The requestor is seeking an additional \$50.00 for charges related to multiple impairment ratings. 28 Texas Administrative Code §134.204(j)(4)(B) states:

When multiple IRs are required as a component of a designated doctor examination ..., the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR **calculation** [emphasis added]. Modifier "MI" shall be added to the MMI evaluation CPT code.

Further, 28 Texas Administrative Code §134.204(j)(1) requires that:

The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include:

- (A) the examination;
- (B) consultation with the injured employee;
- (C) review of the records and films;
- (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), **calculation tables** [emphasis added], figures, and worksheets; and,
- (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

2. Review of the submitted documentation finds that the requestor did not meet the examination requirements in accordance with the applicable fee guidelines. Therefore, the division finds that no further reimbursement can be recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 20, 2016  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**